**** Form 2935

October 2023



Admission Information

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| **General Information** | | | | | | | | | | |
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| Operation’s Name:  **Excelencia – Creative Bilingual Preschool** | | | Director’s Name: | | | | | | | |
| Child’s Full Name: | | | Child’s Date of Birth | Child Lives With:  Both Parents  Mom  Dad Guardian | | | | | | |
| Child’s Home Address: | | | | | | Date of Admission | | | | Date of Withdrawal |
| Name of Parent or Guardian Completing Form | | | Address: (if different from the child’s) | | | | | | | |
| List phone numbers below where parents or guardian may be reached while child is in care. | | | | | | | | | | |
| Parent 1 Phone No.: | Parent 2 Phone No.: | | Guardian’s Phone No.: | | | | | Custody Documents on File?  Yes  No | | |
| Parent 1 E-mail: | | Parent 2 E-mail: | | | | | Guardian’s E-mail: | | | |
| **In case of an emergency, call:** | | | | | | | | | | |
| Name of Emergency Contact: | | | Relationship: | | | | | | Area Code and Phone No.: | |
| Address: | | | | | | | | | | |
| I authorize the Excelencia Preschool **to release** my child to leave the preschool **ONLY** with the following persons. Please list the name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID. | | | | | | | | | | |
| Name: | | | | | Area Code and Phone No.: | | | | | |
| Name: | | | | | Area Code and Phone No.: | | | | | |
| Name: | | | | | Area Code and Phone No.: | | | | | |

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| **Consent Information** |
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| 1. **Transportation** (Check all that apply) |
| I give consent for my child to be transported and supervised by Excelencia staff:  for emergency care  ~~on field trips~~  to and/or from home  to and/or from |
| 1. **2. Field Trips** (are not offered) |
| ~~O I give consent for my child to participate in field trips. O I do not give consent for my child to participate in field trips.~~ |
| Comments: |
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| **3. Water Activities** | |
| I give consent for my child to participate in the following water activities: (Check all that apply)  Water table play  Splash pad  Sprinkler play  small wading pool | |
| Is your child able to swim without assistance?  Yes  No | Does your child have any physical, health, behavioral, or other condition that would put them at risk while swimming?  Yes  No  N/A |
| Do you want your child to wear a lifejacket while in or near a swimming pool?  Yes  No  N/A |

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| **4. Receipt of Written Operational Policies** |
| |  |  | | --- | --- | | I acknowledge receipt of Excelencia Preschool’s operational policies (Parental Handbook) including those for: (Check All that Apply) | | | Discipline and guidance | Procedures for release of children | | Suspension and expulsion | Illness and exclusion criteria | | Emergency plans | Procedures for dispensing medications | | Procedures for conducting health checks | Immunization requirements for children | | Safe sleep | Meal and food service practices | | Procedures for parents to discuss concerns with the director  Promotion of Indoor and outdoor physical activity, including criteria for extreme weather conditions | Procedures to visit Excelencia Preschool without securing prior approval  Procedures for supporting inclusive services | | Procedures for parents to participate in Excelencia activities | Procedures for parents to contact Child Care Regulation, DFPS, Child Abuse Hotline, and CCR website | |

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| **5. Meals** |
| I understand that the following meals will be served to my child while in care: (Check all that apply)  Morning snack  Lunch (parent provided)  Afternoon snack  Pizza on Fridays  Special occasion snacks provided by parents for birthdays, etc. |

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| **6. Days and Times in Care** |

My child is normally in care on the following days and times:

|  |  |  |
| --- | --- | --- |
| **Day of the Week** | **AM** | **PM** |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |
| Saturday | Closed | Closed |
| Sunday | Closed | Closed |

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| **7. Receipt of Parent’s Rights** |

I acknowledge, I have received a written copy of my rights as a parent or guardian of a child enrolled at Excelencia Preschool.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature – Parent or legal guardian Date Signed

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| **8. Child’s Special Care Needs** (Check All that Apply) |
| |  |  | | --- | --- | | Environmental allergies | Limitations or restrictions on child’s activities | | Food intolerances | Reasonable accommodations or modifications | | Existing illness | Adaptive equipment (include instructions below) | | Previous serious illness | Symptoms or indications of complications | | Injuries and hospitalizations (past 12 months) | Meal and food service practices | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Explain any needs selected above: | Medications prescribed for continuous long-term use | |
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| Does your child have diagnosed food allergies? |

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| **9. School Age Children (**Only complete if your child will attend a K-12 school in addition to Excelencia Preschool) | |
| My child attends the following school: | School Area Code and Phone No.: |
| My child has permission to (check all that apply):   |  | | --- | | walk to or from school or home  ride a bus  be released to the care of his or her sibling under 18 years old | | |
| Authorized pick up or drop off locations other than the child’s address: | |
| N/A | |
| Child’s required, immunizations, vision, and hearing screening, and TB screening are current and on file at their school. | |

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| **Authorization for Emergency Medical Attention** | | |
| In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to: | | |
| Name of Physician: | Address: | Phone No.: |
| Name of Emergency Care Facility: | Address: | Phone No.: |
| I give consent for the facility to secure any and all necessary emergency medical care for my child.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature – Parent or legal guardian Date Signed | | |

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| **Requirements from Exclusion from Compliance** |
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| At Excelencia Preschool we only accept exclusions from compliance for medical reasons. Other reasons for non-compliance, such as reasons of conscience or religious beliefs are not allowed.  I have attached a signed and dated letter from my child’s physician stating that they do not recommend the child receive immunizations for reasons of health or adverse response. |

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| **Vision Exam Results** | |
| (Required within 120 days of 4th birthday) | |
| Right Eye 20 / Left Eye 20 / O Pass O Fail | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed |

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| **Hearing Exam Results** | | | | | |
| (Required within 120 days of 4th birthday) | | | | | |
| **Ear** | **1000 Hz** | **2000 Hz** | | **4000 Hz** | **Pass or Fail** |
| Right |  |  | |  | O Pass O Fail |
| Left |  |  | |  | O Pass O Fail |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature – healthcare Professional | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed | | |

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| **Admission Requirement** |
| If your child does not attend pre-kindergarten or school away from Excelencia Preschool, one of the following must be presented when your child is admitted to Excelencia Preschool or within one week of admission. (**Select only one option)**  Healthcare Professional’s Statement: I have examined the above named child within the past year and find that he or she is able to take part in the daycare program.  A signed and dated copy of a healthcare professional’s statement is attached.  My child has been examined within the past year by the healthcare professional named below, and is able to  participate in a daycare program. Within 12 months of admission, I will provide a written, signed, healthcare  professional’s statement to Excelencia Preschool.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of healthcare professional, if selected Address of Healthcare Professional, if selected  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature – Healthcare Professional Date Signed  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature – Parent or Legal Guardian Date Signed | |

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| **Vaccine Information** | | |
| The following vaccines require multiple doses over time. Please provide the date your child received each dose. | | |
| **Vaccine** | **Vaccine Schedule** | **Dates received** | |
| Hepatitis B | Birth (first dose) |  | |
| 1 – 2 months (second dose) |  | |
| 6–18 months (third dose) |  | |
| DTaP (Diphtheria, Tetanus, and Pertussis) | 2 months (first dose) |  | |
| 4 months (second dose) |  | |
| 6 months (third dose) |  | |
| 15-18 months (fourth dose) |  | |
| 4 – 6 years (fifth dose) |  | |
| Haemophilus Influenza Type B (Hib) | 2 months (first dose) |  | |
| 4 months (second dose) |  | |
| 6 months (third dose) |  | |
| 12-15 months (fourth dose) |  | |
| Pneumococcal (PNV-13) | 2 months (first dose) |  | |
| 4 months (second dose) |  | |
| 6 months (third dose) |  | |
| 12-15 months (fourth dose) |  | |
| Inactivated Polio Virus (IPV) | 2 months |  | |
| 4 months |  | |
| 6–18 months |  | |
| 4 – 6 years |  | |
| MMR (Measles, Mumps, Rubella) | 12-15 months (first dose) |  | |
| 4 – 6 years (second dose) |  | |
| Varicella | 12-15 months (first dose) |  | |
| 4 – 6 years (second dose) |  | |
| Hepatitis A | 12-23 months (first dose) |  | |
| The second dose should be given 6 - 18 months after the first dose. |  | |

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| **Varicella (Chickenpox)** | |
| Varicella (chickenpox) vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date)       and does not need the varicella vaccine. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed | |

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| **Additional Information Regarding immunizations** |
| For additional information regarding immunizations, visit the Texas Dept. of State Health Services website at [www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm). |

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| **Gang Free Zone** |
| Under the Texas Penal Code, any area within 1000 feet of a child care center is a gang free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties. |

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| **Privacy Statement** |
| HHSC values your privacy. For more information, read our privacy policy online at [www.hhs.texas.gov/policies-practices-privacy#security](http://www.hhs.texas.gov/policies-practices-privacy#security) |

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| **Signatures** | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child’s Parent or Legal Guardian | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Excelencia Preschool Designee | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed |
| **Physician or Public Health Personnel Verification** | |
| Signature or stamp of physician or public health personnel verifying immunization information above.   |  |  | | --- | --- | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Signed | | |